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Case report

Spontaneously resolved gigantic retroperitoneal haematoma following oophorectomy: A case report in a cardiac patient on anticoagulant therapy

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Abstract *Introduction:* Retroperitoneal haemorrhage is a clinical entity that can present as a rare life-threatening event, causing significant morbidity and representing a diagnostic challenge.
Case presentation: We report the case of a patient with double mitral and aortic valve replacement on oral anticoagulant who presented with retroperitoneal haematoma after left oophorectomy for ruptured huge ovarian cyst which was treated conservatively.
Conclusion: Delay in diagnosis is potentially fatal and high clinical suspicion remains crucial. Finally, it is a matter of controversy whether retroperitoneal haematomas should be surgically evacuated or conservatively treated and the final decision should be made after taking into consideration patient's general condition and the possibility of permanent femoral or sciatic neuropathy due to compression syndrome.

1. Case report

A 40-year-old woman, P4 + 0, with two previous caesarean sections, was admitted to our department, complaining of lower abdominal pain, distension, dizziness, headache and pallor since 4 h. She was a cardiac patient with aortic and mitral valve replacement on warfarin 5 md/d.

On examination, the patient was drowsy, in agony and in a nearly shock state with pale, cold, clammy extremities, a thready pulse of 120 beats/minute and arterial blood pressure of 70/40 mmHg.

Abdominal examination revealed distension and tenderness all over. On vaginal examination, mild vaginal bleeding was noted. A speculum examination did not reveal any cervical or vaginal pathology. The cervical os was tightly closed. The patient was resuscitated with intravenous fluids plasma and blood transfusion.

Pelvic ultrasound showed an NS-AVF uterus, with massive abdominal collection which revealed blood on abdominal tapping. Her Hb was 3 g/dl, platelets count of 80,000/cmm, and INR 10.

The patient underwent a low transverse abdominal incision (Pfannenstiel) after stabilization of the general condition. Drainage of clotted blood was done. Right oophorectomy was done for ruptured large ovarian cyst that was sent for

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histopathology. Histopathology later revealed simple ovarian cyst. There were no operative complications. No unusual bleeding was observed. Intraperitoneal drain was inserted. She had received 4 units of blood and 2 units of fresh frozen plasma intraoperative.

Postoperative, LMWH (enoxaparin 40 mg/d) was started 12 h after the operation with warfarin 3 mg/d.

On the fourth day post-operation, she started complaining of tachycardia, tachypnoea, abdominal pain and distension while still receiving her transfusions. The drain was showing about 600 cc/day. She was investigated for the aetiology of the abdominal pain. Her general condition was average and she was conscious. Her temperature was 37.8°°C, blood pressure was 100/70 mmHg and pulse was 88/minute. Her abdomen was distended and was tender to palpation. She had no problem passing flatus or urine. Her complete blood count results were: haemoglobin 6 g/dl, haematocrit 25% (NR 35–53), platelets 80,000/cmm, and white blood cells 17,000/μl. Her biochemistry results were prothrombin time 30%. Chest X-ray was normal.

An abdominal ultrasound showed a 10×20 cm hypoechoic haematoma extending from the pelvis to just below the left kidney with no free abdominal collection.

Computerised tomography (CT) scan of the abdomen reported a large hypodense non-enhancing collection about $20 \times 12 \times 10$ cm extending from the left iliac fossa, to the upper pole of the left kidney. The main bulk of the collection displaced the left kidney antero-medically; otherwise both kidneys and ureters were normal. It merged imperceptibly with the psoas muscle, indicating a haematoma originating in the retroperitoneal (Fig. 1).

No further action was taken regarding the retroperitoneal haematoma. She was managed conservatively with bed rest, analgesia and antibiotics, continuing blood and plasma replacement. Anticoagulant therapy was stopped. One week after the haematoma was noticed, her abdominal pain started to subside. A repeat ultrasound scan failed to identify increase in size. The patient discharged after 2 weeks later on oral anticoagulant after reintroduction for her cardiac condition. Follow-up CT scans showed the gradual resorption of the retroperitoneal haematoma over a period of nine months. She has been on follow-up with no evidence of complication.

2. Discussion

Haemorrhage may occur but this appears to be one of the few reports in the literature of giant retroperitoneal haematoma following oophorectomy. Most commonly reported causes of spontaneous retroperitoneal haemorrhage include rupture of abdominal aortic aneurysm, adrenal bleeding, haemorrhagic pancreatitis and kidney-related haemorrhage occurring secondarily to spontaneous rupture of renal cell carcinoma, angiomyolipoma or renal cysts or as a result of blood dyscrasia or anticoagulation therapy. [1]

Patients with retroperitoneal haemorrhage usually present with abdominal pain, nausea and vomiting, ileus, a tender mass in the abdomen and flank, hypotension and a marked decrease in haematocrit [1]. Abdominopelvic CT scan is the

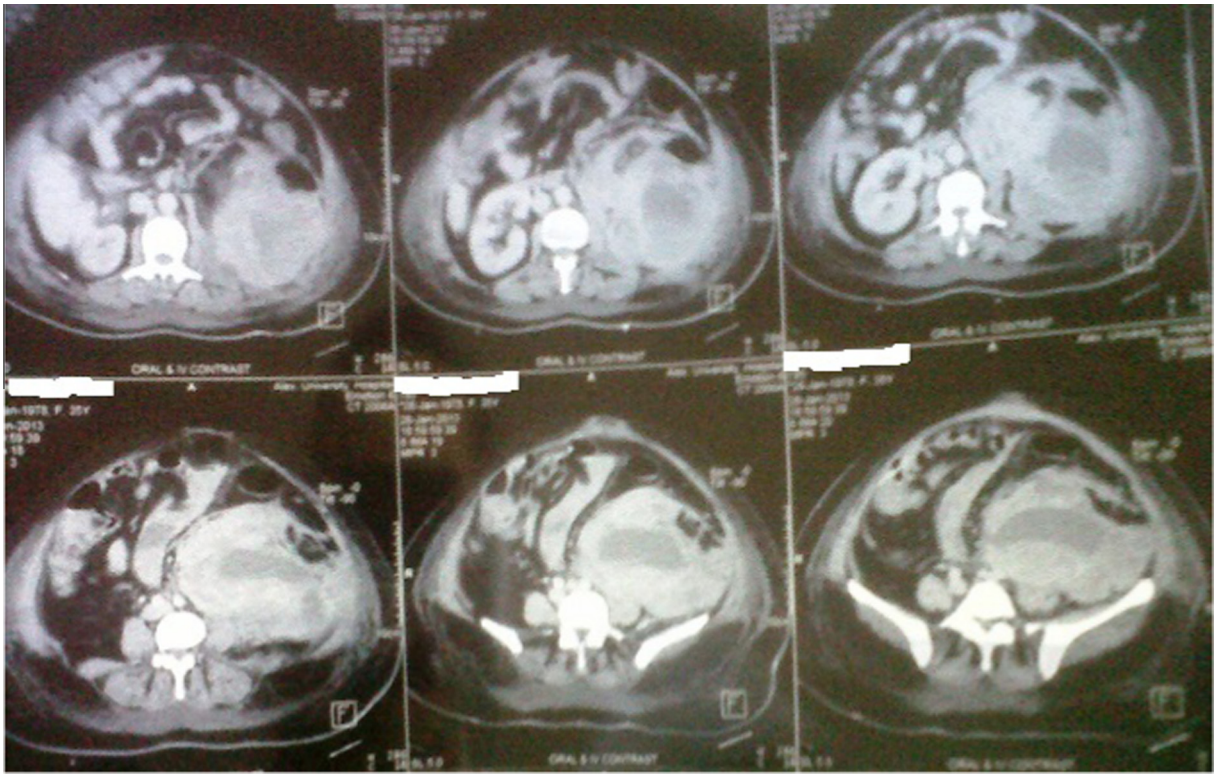

Figure 1 Abdominal CT revealed retroperitoneal haematoma.

principal method of diagnosis. It helps in establishing the site, size and likely underlying cause [2]. According to Henao and Aldrete [3], retroperitoneal haematoma patients who are in shock or who have peritoneal irritation or positive peritoneal lavage results should undergo operation, while others do not require urgent operation but should be placed under observation. According to Kent et al. [4], only 16% of patients require surgery, indications for surgical intervention including persistent hypotension, decreasing haematocrit despite transfusion, and femoral neuropathy due to nerve compression. They suggest that laparotomy may sometimes be harmful due to destroying the tamponade effect of the abdominal wall.

Conflict of Interest

None.

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